



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-05-9375-01
RHD MEMORIAL MEDICAL CENTER PO BOX 819094 DALLAS TX 75381-9094	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Dallas County Schools Box #: 42	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "CARRIER DENIED PROVIDER'S APPEAL CITING THE REASON THAT IT HAD PREVIOUSLY REIMBURSED AT THE MEDICARE RATE +200% THE COMMISSION HAS NOT YET ADOPTED THE MEDICARE RATE AS AN ACCEPTED METHOD OF REIMBURSING OURPTAITENT SERVICES WHICH HAVE BEEN PROVIDED BY HOSPITALS. THEREFORE, PROVIDER SEEKS AN ORDER FROM THE COMMISSION, FOR THE CARRIER TO REMITT THE HEREIN DISPUTED AMOUNT TO THE PROVIDER AND SEEKS A COMPLIANCE AND PRACTICE REFERAL FOR UTILIZING A METHOD OF REIMBURSEMENT NOT ADOPTED BY THE COMMISSION AT THE TIME SERVICES WERE RENDERED." [sic]

Principal Documentation:

1. DWC 60 Package
2. Medical Bill
3. EOB(s)
4. Medical Records
5. Total Amount Sought - \$7,390.19

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "M – Carrier... F+R reimbursement in compliance w/TWCC rules in absence of Outpt Fee Guideline" [sic]

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/10/2003	M, O	Diagnostic Radiology Services	\$7,390.19	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on August 27, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 21, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - M – PMT AMNT BASED ON MEDICARE GRP RATES AT 200%, MULT.PROC RULE APPLIES

- O – DENIAL AFTER RECONSIDERATION

1. This dispute relates to outpatient diagnostic radiology services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, which states that “Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.”
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(e)(2)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the carrier response to the initial bill submission. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(2)(B).
5. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission.” Review of the requestor’s *Table* finds that the amount listed as billed does not match the total amount billed. The requestor lists the Medical Fee Guideline MAR as “85% of Total Charges,” but the total MAR as “76.5% of Total Charges.” Nor does the amount paid or amount in dispute match the amounts in the totals of the columns. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).
6. Division rule at 28 TAC §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “the requestor’s reasoning for why the disputed fees should be paid.” Review of the submitted documentation finds no documentation of the requestor’s reasoning for why the disputed services should be paid. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(ii).
7. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues.” Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
8. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
9. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s rationale for increased reimbursement from the *Table of Disputed Services* states that “...THE COMMISSION HAS NOT YET ADOPTED THE MEDICARE RATE AS AN ACCEPTED METHOD OF REIMBURSING OURPTAITENT SERVICES WHICH HAVE BEEN PROVIDED BY HOSPITALS. THEREFORE, PROVIDER SEEKS AN ORDER FROM THE COMMISSION, FOR THE CARRIER TO REMITT THE HEREIN DISPUTED AMOUNT TO THE PROVIDER...” [sic]
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
 - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement.

- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor's *Table of Disputed Services* lists the Medical Fee Guideline MAR on the Table of Disputed Services as "85% of Total Charges" and the total Medical Fee Guideline MAR as "76.5% of Total Charges." However, the Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(B), §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
 28 Texas Administrative Code §133.307, §134.1, §134.401
 Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

<hr/> Authorized Signature	Grayson Richardson <hr/> Medical Fee Dispute Resolution Officer	8/26/2010 <hr/> Date
<hr/> Authorized Signature	Martha Luevano <hr/> Medical Fee Dispute Resolution Manager	8/26/2010 <hr/> Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.